

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2011
FORM APPROVED
OMB NO. 0938-0391

454 5/07/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2011
NAME OF PROVIDER OR SUPPLIER HARRIMAN CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HANNAH ROAD HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey, conducted on March 21-23, 2011, at Harriman Care and Rehab, complaint investigations for complaint #27199 and #26762, were also conducted. There were no deficiencies for complaint #27199 cited under CFR PART 483.13, Requirements for Long Term Care.	F 000	Harriman Care & Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>Based on medical record review, observation, and interview, the facility failed to update the care plans to include activities of daily living needs (ADLs) for two residents (#10, #24) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on November 4, 2008, with diagnoses including Depression and Alzheimer's Disease.</p> <p>Medical record review of the physical therapy discharge summary dated March 9, 2011, revealed " ...Nursing staff needs to continue bed program to allow patient to rest which helps ...sitting posture during the day ..."</p> <p>Medical record review of the care plan updated March 15, 2011, revealed the bed program was not addressed on the care plan.</p> <p>Observation on March 21, 2011, at 9:20 a.m., revealed the resident seated in high back wheelchair leaning to the left side, with the left arm hanging down over the arm of the wheelchair without support.</p> <p>Interview with the Unit Manager on March 21, 2011, at 4:00 p.m., confirmed the resident had a history of leaning to the left side. Continued interview revealed the bed program was to lay the resident down after meals for rest periods and this was not updated on the resident's care plan.</p> <p>Resident # 24 was readmitted to the facility on</p>	F 279	<p>F - 279 Develop Comprehensive Care Plans.</p> <p>1. The bed program for Resident #10 was added to the care plan on 3/23/11 to lay resident down in bed for naps after meals. Resident #24 was a closed record review and is not currently a resident at the facility. The grievance forms were up-dated on 4/9/11 to include a care planning option to ensure that care plans are up-dated as needed with any care intervention changes.</p> <p>2. Residents have the potential to be affected.</p> <p>3. Therapy department, MDS Coordinators, Unit Managers, and Social Service Director will be in-serviced by the Director of Nursing or designee on or before 4/20/11 regarding up-dating resident care plans with any changes in</p>	4/21/11	

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F 279	<p>Continued From page 2</p> <p>August 27, 2010, with diagnoses including Congestive Heart Failure, Renal Failure, Muscle Weakness, Diabetes Mellitus, Dementia, and Cardiomyopathy.</p> <p>Medical record review of the Minimum Data Set dated September 2, 2010, revealed the resident had some short-term memory problems and had mild cognitive difficulty in new situations only.</p> <p>Medical record review of a Social Service Progress Note dated September 2, 2010, revealed "...resident expressed concerns about...care. Green form filled out. Unit Manager to address concerns..."</p> <p>Medical record review of Resident/ Visitor/Grievance/Complaint Form dated September 2, 2010, completed by RN (Registered Nurse) #1, revealed "...Resident's family asked Social Services to speak to resident because (resident) had some concerns. Resident states...feels...is not being treated well. Res. (resident) said sat in...recliner until...feet swelled. Res. also requested to be laid down b/c (because)...w/c (wheelchair) was in front of...bed. Then res. said...had too many blankets on...and...couldn't move. Res. also says people are not helping...turn in...bed. Res says staff tells...(resident) to do it...res reports...laid in bed for 5 hours before someone actually turned...res says...really wants staff to be patient with (resident)..." Continued review revealed "...Action Taken: Staff inserviced..." Documentation of the Inservice conducted on September 8, 2010, during which staff was inserviced on care of the resident included "...1. When (resident) requests to be turned even if it has not been two hours, turn (resident). 2. When (resident) asks to be put</p>	F 279	<p>care interventions related to resident grievance forms and therapy plans. Director of Nursing or designee and Director of Social Services or designee will conduct an audit of the grievance forms weekly x 4 weeks to ensure that care plans are up-dated as needed.</p> <p>4. Audit findings will be reported by the DON or designee to the PI committee at the next monthly meeting. (PI committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD). PI Committee will Review, discuss and make any necessary revisions or recommendations.</p>		

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F 279	Continued From page 3 to bed PUT (resident) to bed. 3. Answer call light in a timely manner..." Medical record review of the Comprehensive Care Plan, page #7, dated September 15, 2010, revealed "...Problem: resident has ADL (activities of daily living) Self Care Deficit & is at risk for complications related to Deficit. Resident needs moderate assistance with ADL's due to CHF (Congestive Heart Failure), weakness..." with approaches including "...Staff to provide only the amount of assistance/supervision to meet the Resident's needs for all ADL's, Turn and reposition, shifting weight to enhance circulation, and Staff to assist with transfers as needed..." Interview with Social Worker #1, on March 23, 2011, at 2:05 p.m., in the conference room, confirmed the resident's Care Plan had not been updated to reflect the care interventions documented in the September 8, 2010, inservice. Complaint #26762	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to notify the physician of laboratory results, resulting in a delay in treatment of a urinary tract infection, for one resident (#11), and failed to follow	F 281			

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F 281	<p>Continued From page 4</p> <p>physician's orders for one (#24) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on June 5, 2007, with diagnoses including Vascular Dementia, Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, Arthritis and Adult Failure to Thrive.</p> <p>Medical record review of a physician's telephone order dated February 7, 2011, at 12:45 p.m. revealed, "...UA (urinalysis) C&S (with culture and sensitivity) 2-8-11 Dx. (diagnosis) recurrent UTI (Urinary Tract Infection) ..."</p> <p>Medical record review of a physician's Nursing Home Encounter form dated February 7, 2011, revealed "...Assessment: Recurrent UTI and Plan: UA C&S, F/U (follow up) results..."</p> <p>Medical record review of a nurses note dated February 8, 2010, at 12:00 a.m. revealed, "...UA obtained via sterile tech. (technique)..."</p> <p>Medical record review of the Lab Tracking Log for February, 2011, revealed a notation of the resident's name, room number, diagnostic test as the UA C&S, date the test completed, no notation of notification of results to physician or nurse practitioner.</p> <p>Medical record review of the urine culture final report dated February 11, 2011, at 11:19 a.m., revealed "...Organism 1 Escherichia coli..." with the notation "...called to Hospis (Hospice) 4PM</p>	F 281	<p>F-281 Services Provided Meet Professional Standards.</p> <p>1. FNP ordered Antibiotic treatment for resident #11 on 2/16/11. (Tobramycin IM x 7 days). Resident #24 was a closed record review.</p> <p>2. Residents with UTI's have the potential to be affected.</p> <p>3. Unit Managers and Charge Nurses will be in-serviced by the Director of Nursing or designee regarding timely MD notification of lab results by 4/19/11. Labs are to be audited by Director of Nursing or designee five days per week for two weeks and then weekly for two weeks and then monthly for three months for timely MD notification. Charge Nurses will be in-serviced by 4/19/11 by Director of Nursing or designee concerning following the facility bowel</p>		5/2/11

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F 281	<p>Continued From page 5 2-15-11..."</p> <p>Medical record review of a physician's telephone order dated February 16, 2011, at 1:20 p.m., revealed "...Tobramycin for UTI X (times) 7 days IM (intramuscularly) Pharmacy to manage dosing..."</p> <p>Review of the facility policy "Laboratory Protocol/Diagnostic Testing/Reporting", revealed "...d. Documentation of MD notification and any new orders will be noted on T. O. (telephone order), NN (nurses note) and Lab/Diagnostic Log. e. Once results are received and reviewed, documentation will be completed on the Lab/Diagnostic Log. f. Abnormal labs will be called to the MD for follow-up at the time of receipt with information noted on the lab to include date, time, initials and orders..."</p> <p>Interview with LPN (licensed practical nurse) #4 on March 22, 2011, at 1:20 p.m., at the 100 hall nursing station, revealed "...I talked to NP (Nurse Practitioner) on February 11, 2011, who said (NP) would order Tobramycin if OK with Hospice (resident under Hospice care). I called Hospice February 11, 12, 13, 14, 15, with no response and on the 16 the NP said (NP) would go ahead and order Tobramycin..."</p> <p>Interview with the DON (Director of Nursing) and LPN # 4 on March 22, 2011, at 1:30 p.m., at the 100 hall nursing station, confirmed there was no documentation Hospice was notified of laboratory results until February 15, 2011, and no documentation the physician or NP was made aware of the results until February 16, 2011, when the above Physician's order for Tobramycin was obtained. (a five day delay)</p>	F 281	<p>regimen protocol. The Director of Nursing or designee will conduct an audit of the bowel sheets two days per week for two weeks and then weekly for two months.</p> <p>4. Audit findings will be reported by the DON to the PI Committee monthly until the audit schedule is completed. (PI committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD). PI Committee will review, discuss and make any necessary revisions or recommendations.</p>		

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F 281	<p>Continued From page 6</p> <p>Resident # 24 was readmitted to the facility on August 27, 2010, with diagnoses including Congestive Heart Failure, Renal Failure, Muscle Weakness, Diabetes Mellitus, Dementia, and Cardiomyopathy.</p> <p>Medical record review of the Minimum Data Set dated September 2, 2010, revealed the resident had some short-term memory problems and had mild cognitive difficulty in new situations only.</p> <p>Medical record review of the "BM (Bowel Movement) Record/ Regimen Flow Sheet" for September 2010, revealed no bowel movement documented September 1-6, (six days), and a notation "...Last BM 8/29..."</p> <p>Medical record review of the Physician's Orders for September 1-30, 2010, revealed "...if no BM X (times) 3 days admin. (administer) ii tabs (two tablets) Bisacodyl @ (at) 8 pm ...If no BM by AM of 4th day admin. Bisacodyl supp (suppository) rectally ...if no BM by PM of 4th day admin. Fleets enema till clear ..."</p> <p>Medical record review of the Medication Administration Record for September 1-30, 2010, revealed the resident had received two Bisacodyl tablets at 8:00 p.m. on September 1, 2010, and no further interventions documented for the month of September.</p> <p>Interview with the DON on March 23, 2011, at 11:30 a.m., in the conference room, confirmed the resident had no bowel movement documented September 1-6, 2010, and the facility failed to follow the physician's orders.</p>	F 281			

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F 281	Continued From page 7	F 281			
	Complaint #26762				
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide nail care for one (#3) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on March 24, 2005, with diagnoses including Macular Degeneration, Vascular Dementia, and Mood Disorder.</p> <p>Medical record review of the Minimum Data Set dated February 27, 2011, revealed resident #3 had impaired short and long term memory and required assistance with all activities of daily living.</p> <p>Observation on March 21, 2011, at 1:30 p.m., and at 2:15 p.m., at the 300/400 nurse's desk; and on March 22, 2011, at 8:35 a.m., and 11:00 a.m., in</p>	F 312	<p>F- 312 ADL Care Provided for Dependent Residents.</p> <p>1. Resident #3 toe nails trimmed and finger nails cleaned on 3/23/11.</p> <p>2. Residents have the potential to be affected.</p> <p>3. Nursing staff will be in- serviced on nail care by 4/20/11 by the Director of Nursing or designee. A 10% random audit will be conducted weekly x 4 weeks by DON or designee to ensure that residents have received adequate nail care.</p> <p>4. Audit findings will be reported by the DON to the PI Committee monthly. (PI committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD). PI Committee will review, discuss and make any necessary revisions or recommendations.</p>		5/2/11

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F 312	Continued From page 8 the resident's room; and at 1:20 p.m., near the chapel, revealed the resident with dark brown debris under the fingernail tips on both hands. Continued observation on March 23, 2011, at 8:00 a.m., in the main dining room revealed the resident feeding self breakfast with dark brown debris under the fingernail tips. Observation and interview on March 23, 2011, at 10:05 a.m., in the main dining room, with Licensed Practical Nurse (LPN) #3 confirmed the resident had dark brown debris under the fingernail tips and required cleaning. Observation on March 23, 2011, at 11:30 a.m., with the Nurse Practitioner (NP) and LPN #2 revealed all five of the resident's right foot toenails were ¼ to ½ centimeters long and sharp. Interview with the NP and LPN #2, during the observation, confirmed the resident's toenails required trimming.	F 312			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441			

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F 441	<p>Continued From page 9</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to wash or sanitize the hands before touching resident food, distributing resident food trays, and feeding residents for one of two meal observations in the main dining room.</p> <p>The findings included:</p> <p>Observation on March 23, 2011, at 7:45 a.m., in the main dining room, revealed Certified Nurse Assistant (CNA) #1 was distributing food trays to the residents. Continued observation revealed, without sanitizing the hands or wearing gloves,</p>	F 441	<p>F-441 Infection Control, Prevent Spread, Linens</p> <p>1. CNA #1 was in-serviced on 4/1/11 by DON regarding infection control procedures during meal service delivery.</p> <p>2. Residents have the potential to be affected.</p> <p>3. Nursing staff will be in-serviced regarding infection control procedure regarding meal service delivery by 4/20/11 by Director of Nursing or designee. Random audits to be completed by Director of Nursing or designee during meal service delivery for three meals per week x 4 weeks.</p> <p>4. Audit findings will be reported by the DON to the PI Committee. (PI committee consists of/ minimally: Administrator, DON, Unit Managers, and SSD). PI Committee will review, discuss and make any necessary revisions or recommendations.</p>	5/2/11

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NAME OF PROVIDER OR SUPPLIER HARRIMAN CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HANNAH ROAD HARRIMAN, TN 37748		
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F 441	<p>Continued From page 10</p> <p>CNA #1 picked up a piece of sausage and attempted to hand it to a resident; set the sausage on the plate; and picked up the resident's pancakes and tore them into small pieces. Continued observation revealed, without sanitizing the hands or wearing gloves, CNA #1 continued to deliver trays to other residents and, without sanitizing the hands or wearing gloves, began feeding another resident.</p> <p>Interview on March 23, 2011, at 7:55 a.m., in the main dining room with Licensed Practical Nurse #1 confirmed touching resident food, distributing resident food trays, and feeding residents was to be done with gloved and/or sanitized hands to protect the residents from the spread of germs.</p>	F 441			